HOLROYD PRIVATE HOSPITAL
MACQUARIE HEALTH CORPORATION

REFERRAL/REHABILITATION & MEDICAL PRE-ADMISSION FORM

PLEASE USE GUMMED LABEL IF AVAILABLE

SURNAME
GIVEN NAMES
D.O.B. SEX
WARD DOCTOR
UNIT NUMBER

PHONE: 02 9681 2222 FAX REFERRALS TO: 9632 8480 OR EMAIL TO: holroyd.info@machealth.com.au

PROGRAMME TYPE: INPATIENT OUTPATIENT

Program Type ☐ Heart Wellness (Cardiac Rehab) ☐ Orthopaedic ☐ Reconditioning ☐ Falls Prevention ☐ Neurological
☐ Pain Management ☐ Respiratory ☐ Other

REFERRAL DETAILS

Date of referral: / / | Expected admision date: / / | Referring doctor:
Referring from: ☐ Home ☐ Hospital | Date of hospital admission: / / | Ward:
Referring hospital: | Phone: | Fax:
Was patient transferred from another hospital: ☐ Yes ☐ No | Previous hospital: | Date of admission: / /
GP: | Phone:

PATIENT DETAILS

Name: | Title: | Marital Status:
Language/s spoken at home: | DOB: / / | Age: | Sex:
Address:
Country of birth: | Religion: | Occupation:
Phone - Home: | Phone - Work: | Mobile:
Next of kin: | Relationship: | Phone:
Are you of Aboriginal/Torres Strait Islander (TSI) Descent? ☐ No ☐ Aboriginal ☐ TSI ☐ Both Aboriginal & TSI

MEDICARE / PENSION / INSURANCE DETAILS

Medicare No.:__________ Expiry Date:____/____ ID No:______ Pension No.:__________
Private Health Fund:__________ Membership No.:__________
DVA No.:__________ Type of DVA Card:__________
Is the patient claiming Workers Compensation: ☐ Yes ☐ No Is the patient claiming Third Party: ☐ Yes ☐ No
Insurance Co.:__________ Claim No.:__________ Contact No.:__________

CLINICAL DETAILS

Presenting Diagnosis for Acute Admission:__________
__________ Date of Op/Accident: ____/____/____
Diagnosis/Procedure in Acute Admission:__________
Reason for Rehab Admission:__________
Mediacal History:__________
__________ Allergies:__________
Current Medication:__________

Recent ACAT Assessment: ☐ Yes ☐ No Details:__________
Medical requirements: Weight:_____kgs ☐ Diabetic ☐ ECG ☐ O2 ☐ IV ☐ CVC ☐ PICC
Physical requirements: Is specialised hospital equipment required: ☐ Yes ☐ No Type:__________
Social history: ☐ Lives alone ☐ Lives with partner ☐ Lives with carer ☐ Lives with relative
Type of accommodation: ☐ Home/Unit ☐ Retirement Home ☐ Low Level Care ☐ High Level Care
Premorbid ADL status: ☐ Independent ☐ Supervision ☐ Assistance - ☐ Min ☐ Mod ☐ Full
Community Services: ☐ SHN ☐ MOW ☐ Home Care ☐ Other:__________
Current mental status: ☐ Alert ☐ Orientated ☐ Co-operative ☐ Confused ☐ Dementia
Current mobility status: ☐ Independent ☐ Supervision ☐ Assist ☐ With aids:__________
Current transfers: ☐ Independent ☐ Supervision ☐ Assist
Current self care status: ☐ Independent ☐ Supervision ☐ Assistance - ☐ Min ☐ Mod ☐ Full
Current continence status: ☐ BLADDER ☐ Continent ☐ Incontinent ☐ IDC/SPC
☐ BOWEL ☐ Continent ☐ Incontinent ☐ Colostomy
Weight bearing status: ☐ FWB ☐ WBAT ☐ PWB/TWB ☐ NWB for ______ more weeks
Skin integrity: ☐ Intact ☐ Wound/s ☐ Pressure Area/s
Area/s, type of dressing & frequency:__________
Swallowing intact: ☐ Yes ☐ No ☐ NGT/PEG
Diet: ☐ Normal ☐ Diabetic ☐ Tube Fed ☐ Supplement:__________
☐ Vegetarian ☐ Vegan ☐ Gluten Free
MRSA status: ☐ Yes ☐ No Swabs attended:__________ Date attended:____/____/____

PLEASE SEND PATIENT WITH THREE (3) DAYS SUPPLY OF MEDICATIONS + COPY OF MEDICATION CHART & PHYSIO REPORT

Name:__________ | Designation:__________ | Date:____/____/____

BINDING MARGIN – DO NOT WRITE

MS0114638/05/22 - Version 0